State of Nevada Department of Business and Industry

DIVISION OF INDUSTRIAL RELATIONS

Workers' Compensation Section 400 West King Street, Suite 400 Carson City, Nevada 89703 (775) 684-7265 (telephone) (775) 687-6305 (fax)

REQUEST FOR A ROTATING RATING PHYSICIAN OR CHIROPRACTOR

Name of Requestor:		Date:	
Address:			FAX:
City:			Zip:
Requestor is: Insurer/Third-Party	Administrator;		Injured Employee;
*Injured Employee's Attorney or Representativ			Other (Specify)
*Please provide a signed release or power	of attorney		
Insurer/Third-Party Administrator/			
Association of Self-Insured Employers Name:			Certificate #:
Self-Insured Employer's Name:			Certificate #:
Employer Name:			
Injured Employee's Name:			
Injured Employee's Address:			
City:	State:		Zip:
Social Security Number:	Claim Number:		Date of Injury:
Body Part(s) Codes: Body Part(s) to be evaluated Diagnosis: Name(s) of Doctor(s) who reviewed for post If a specific specialty is ordered by a hearing of	ssible PPD		
FOR ADDITIONAL RA Date(s) of prior PPD Evaluation(s): Name of Treating Physician(s)/Chiropractor Body Part(s) Codes: Body Part(s) to be evaluated:	Prior r(s):	Rating Doctor	r(s):
Diagnosis:			
Reason for additional request:			
If a specific specialty is ordered by a hearing o	r appeals officer, the decisi	on must be atte	nched
INSURER AND INJURE	ED EMPLOYEE ASSIG	NMENT/AG	REEMENT OF RATER
			t/Agreement:
Physician/Chiropractor Assigned or Mutual			
Assigned Rating Physician/Chiropractor's I	· -		
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**Notice to requestor: Hard copy will not follow by mail.